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Standards for Payments

50.000 STANDARDS FOR PAYMENTS

This chapter provides information on claims and encounter submission and receipt of payment by CRS contractors for services rendered under the CRS Program.

50.100 Scope of the ADHS' Liability for Payments to Contractors

1. The ADHS shall bear no liability for the provision of CRS services or the completion of a plan of treatment to any member or eligible individual beyond the date of termination of such individual's eligibility and enrollment.

2. All payments to contractors shall be made pursuant to the terms and conditions of contracts executed between contractor and the ADHS, and in accordance with Administrative rules.

3. CRS Regional Contractors are responsible for any and all subcontracts executed with other parties for the provision of either administrative or management services for the CRS Program, medical services, covered services or for any other purpose.

50.200 Claims Submission

1. CRS providers are reimbursed for covered services by CRS Regional Contractors. CRS Regional Contractors are responsible for the processing and adjudication of claims presented by CRS providers according to the terms of their contracts with those providers. Unless contracts with providers state otherwise, the CRS Regional Contractors shall ensure that 90% of all clean claims are paid within 30 days of receipt of the clean claim and 99% are paid within 90 days of receipt of the clean claim, in accordance with the Balanced Budget Act of 1997. Further, the CRS Regional Contractors shall provide notice of a denial or a reduction of a claim for 90% of the claims within 30 days of the date of receipt of a claim and 99% of the claims within 90 days of the date of receipt of a claim. CRS Regional Contractors also submit claims and encounter information to ADHS for program and financial management purposes.

2. Remittance advices accompanying CRS Regional Contractor's payments to providers must contain, at a minimum, adequate descriptions of all denial and adjustments, the reasons for such denials and adjustments, the amount billed, the amount paid, and their right to file a claim dispute as provided in section 60.000 Grievance and appeals of this policy manual..

3. Claims for services rendered must be initially received by the appropriate CRS Regional Contractor within six months of the date of service or as designated by contract. A provider has up to twelve months to submit a clean claim. Initial claims received more than six months after the services have been rendered shall not be reimbursed.

4. Claims submitted to the CRS Regional Contractors shall include:

   A. Completion of all fields on the appropriate claim forms;

   B. The Provider Services Requisition (PSR) authorization number;

   C. Valid service-specific diagnostic and procedural codes;

   D. Usual and customary charges, which shall be broken out for each valid code submitted;

   E. Accurate modifiers where appropriate;

   F. Operative report for surgical procedures;

   G. Physicians' orders and progress notes for durable medical equipment (DME);

   H. All supportive documentation (reports, progress notes, orders) for services other than surgery (e.g. ICU visits, consultations, admissions); and

   I. All Explanations of Benefits (EOB's) that relate to the claim (CRS is the payor of last resort).

5. Claims submitted without the above information or with inaccurate codes will automatically be returned to the provider for proper resubmission or other disposition.

6. Claims Aging Reports listing the amount of claims received and the length of time they have been in the CRS Regional Contractor's system to be paid are due to CRSA on a monthly basis.

50.300 Collecting Payments for CRS Services

This section pertains to the requirements for CRS Regional Contractors obtaining payment for services provided to CRS members. This includes coordination of benefits and member responsibilities.

50.301 Coordination of Benefits

1. The State of Arizona is the payor of last resort. CRS Contract Providers are to make all reasonable efforts to collect from insurance companies and other third party payors.

2. If a member has insurance which covers the CRS services provided, the member shall not be billed the residual, regardless of the member's payment responsibility.

3. A CRS Regional Contractor is responsible for collecting payments from insurance companies, managed care organizations and all other third party payers in accordance with member and family insurance policies, the CRS Contractor's contractual arrangements with the payers, and all applicable Arizona statutes.

4. Where third party payors deduct co-payments for services in CRS Regional Clinics or Outreach Clinics, ADHS will give credit in lieu of the CRS Regional Contractor collecting the co-payment.

5. When services are provided by the CRS program, which are outside the covered benefits provided by the insurer, the insurer is not required to pay for those services. The family or member is responsible to pay for the remainder of services not covered by third party insurance according to the terms of the contract and the member's payment responsibility.

6. The amount of the payment due from the insurer or other third party payor is as follows:

    A. Third party payors not included as health care services organizations as described under Title 20, Chapter 4, Article 9 shall be billed the provider's usual and customary charges with payments subject to the payor's requirements for deductible and coinsurance.

7. CRS Regional Contractors shall not bill AHCCCS Health Plans for CRS services.

50.302 Member Responsibility

1. A member shall participate in the cost of care by paying for services in the amounts described in Section 20.760, Member Payment Responsibility Standards.

2. The CRS Regional Contractor shall be responsible for collecting co-payments specified in Section 20.760, Member Payment Responsibility Standards.

3. The CRS Regional Contractor shall ensure that a member with a payment responsibility category of less than or equal to 200% FPL is not denied services because of that member's inability to pay a co-payment or deductible.

4. The CRS Regional Contractor is responsible for collecting applicable payment amounts from members with a payment category of greater than 200%FPL. The CRS Regional Contractor shall not deny services because of a member's inability to pay a co-payment or deductible.

5. The CRS Regional Contractors may recover from a member that portion of payments made by a third party payor to the member when such payment duplicates CRS benefits and has not been assigned to the CRS Regional Contractor.

6. Claims for CRS services shall not exceed the CRS Regional Contractor's or the subcontractor's usual and customary rates.

7. A CRS Regional Contractor may bill a member or family for medical expenses incurred during a period of time when the member or family willfully withholds material information from the CRS Regional Contractor or provides false information pertaining to CRS, AHCCCS, KidsCare, or private insurance eligibility or enrollment status that results in denial of payment due to failure to disclose such information or the provision of false information.

8. The CRS Regional Contractors or their designees must adhere to the prior authorization requirements of all health service organizations. Neither families nor the CRS Program are responsible for the payment of services where payment was denied by a third party payor due to the fact that the CRS Regional Contractor failed to comply with preauthorization or other utilization management procedures.

50.400 Denied Claims

1. CRS Regional Contractors will provide written notifications to providers for all claims that are denied in part or for which a partial payment is made.

2. Notifications must contain:

   A. Date of denial;

   B. Services being denied or not included in payment;

   C. Reason for the denial or reduction in payment; and

   D. Providers right to file a claim dispute and how to do so.